		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021238

Facility Name: P A Peterson Home F/T Aged

Address: 1311 Parkview Ave. (Number) Rockford, Illinois (City) 61107 (Zip Code)

County: Winnebago

Telephone Number: (815) 399-8832 **Fax #** (815) 399-8342

IDPA ID Number: 36-2584799-004

Date of Initial License for Current Owners: 1941

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (C) (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Dorkas Cruz **Telephone Number:** (847) 635-4633

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Frederick Aigner
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 172 8/14/00

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	112	Skilled (SNF)	120	43,448	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	56	Sheltered Care (SC)	52	19,156	5
6		ICF/DD 16 or Less			6
7	168	TOTALS	172	62,604	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			8,307	8,307	8
9	SNF/PED					9
10	ICF	4,649	23,549		28,198	10
11	ICF/DD					11
12	SC		8,951		8,951	12
13	DD 16 OR LESS					13
14	TOTALS	4,649	32,500	8,307	45,456	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.61%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [N/A]

I. On what date did you start providing long term care at this location?
Date started 1941

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 8,307

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/01 Fiscal Year: 6/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	288,491	32,389	35,000	355,880		355,880		355,880			1
2	Food Purchase		265,210		265,210		265,210	(8,090)	257,120			2
3	Housekeeping	117,012	33,502	3,576	154,090		154,090		154,090			3
4	Laundry		1,614	92,366	93,980		93,980		93,980			4
5	Heat and Other Utilities			207,929	207,929	2,765	210,694	(10,768)	199,926			5
6	Maintenance	111,217	30,219	76,714	218,150	6,138	224,288	(2,404)	221,884			6
7	Other (specify):* Rubish/Medical waste			12,536	12,536	1,124	13,660		13,660			7
8	**TOTAL General Services**	516,720	362,934	428,121	1,307,775	10,027	1,317,802	(21,262)	1,296,540			8
	B. Health Care and Programs											
9	Medical Director			18,707	18,707		18,707		18,707			9
10	Nursing and Medical Records	2,559,149	361,126	8,998	2,929,273		2,929,273		2,929,273			10
10a	Therapy	3,874		698,985	702,859		702,859		702,859			10a
11	Activities	99,458	4,327	967	104,752		104,752		104,752			11
12	Social Services	71,256			71,256		71,256		71,256			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,733,737	365,453	727,657	3,826,847		3,826,847		3,826,847			16
	C. General Administration											
17	Administrative	67,108			67,108	214,353	281,461		281,461			17
18	Directors Fees											18
19	Professional Services			747,784	747,784	(450,405)	297,379	95,754	393,133			19
20	Dues, Fees, Subscriptions & Promotions			41,679	41,679	29,455	71,134	(15,916)	55,218			20
21	Clerical & General Office Expenses	149,248	40,689	65,763	255,700	50,609	306,309		306,309			21
22	Employee Benefits & Payroll Taxes			665,610	665,610	39,142	704,752		704,752			22
23	Inservice Training & Education					6,980	6,980		6,980			23
24	Travel and Seminar			13,136	13,136		13,136		13,136			24
25	Other Admin. Staff Transportation					9,308	9,308		9,308			25
26	Insurance-Prop.Liab.Malpractice			23,101	23,101	13,126	36,227	(255)	35,972			26
27	Other (specify):* Fund Raising					5,398	5,398	(5,398)				27
28	**TOTAL General Administration**	216,356	40,689	1,557,073	1,814,118	(82,034)	1,732,084	74,185	1,806,269			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,466,813	769,076	2,712,851	6,948,740	(72,007)	6,876,733	52,923	6,929,656			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number P A Peterson Home F/T Aged #0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			352,737	352,737	32,065	384,802	(7,254)	377,548			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			256,091	256,091	8,425	264,516	(5,175)	259,341			32
33	Real Estate Taxes			122,094	122,094	244	122,338	(1,345)	120,993			33
34	Rent-Facility & Grounds					28,906	28,906		28,906			34
35	Rent-Equipment & Vehicles			33,606	33,606	2,367	35,973		35,973			35
36	Other (specify):*											36
37	**TOTAL Ownership**			764,528	764,528	72,007	836,535	(13,774)	822,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,327	66,327		66,327		66,327			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			66,327	66,327		66,327		66,327			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,466,813	769,076	3,543,706	7,779,595		7,779,595	39,149	7,818,744			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,090)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,768)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(183)	30		9
10	Interest and Other Investment Income	(62)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(2,822)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(15,916)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	77,260			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 39,419		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	(270)	30	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (270)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 39,149		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

P A Peterson Home F/T Aged

ID# 0021238

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non LTC Space Depreciation	$ (3,887)	30	1
2	Non LTC Space Insurance	(255)	26	2
3	Non LTC Space utilities	(2,291)	32	3
4	Non LTC Space Ma	(2,404)	6	4
5	Non LTC Space R/E	(1,345)	33	5
6	Allowable Mgmt & HR Allocation	87,570	19	6
7	Allowable Service Network Allocation	8,684	19	7
8	Advertising & Promotion Management	(4,273)	27	8
9	Advertising & Promotion Serv. Network	(1,125)	27	9
10	Offset Insurance Premium Overpymt refund	(500)	19	10
11	Programs Auto (over one limit)	(1,634)	30	11
12	Management Auto Depreciation	(1,280)	30	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	77,260		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,090)	0	0	0	0	0	0	0	0	0	0	(8,090)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(10,768)	0	0	0	0	0	0	0	0	0	0	(10,768)	5
6	Maintenance	(2,404)	0	0	0	0	0	0	0	0	0	0	(2,404)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(21,262)	0	0	0	0	0	0	0	0	0	0	(21,262)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	95,754	0	0	0	0	0	0	0	0	0	0	95,754	19
20	Fees, Subscriptions & Promotions	(15,916)	0	0	0	0	0	0	0	0	0	0	(15,916)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(255)	0	0	0	0	0	0	0	0	0	0	(255)	26
27	Other (specify):*	(5,398)	0	0	0	0	0	0	0	0	0	0	(5,398)	27
28	**TOTAL General Administration**	74,185	0	0	0	0	0	0	0	0	0	0	74,185	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	52,923	0	0	0	0	0	0	0	0	0	0	52,923	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(7,254)	0	0	0	0	0	0	0	0	0	0	(7,254)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(5,175)	0	0	0	0	0	0	0	0	0	0	(5,175)	32
33	Real Estate Taxes	(1,345)	0	0	0	0	0	0	0	0	0	0	(1,345)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(13,774)	0	0	0	0	0	0	0	0	0	0	(13,774)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	39,149	0	0	0	0	0	0	0	0	0	0	39,149	45

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Vesper Mgmt Corp.	Des Plaines Il	Mgmt Co.
				LSSI	Des Plaines Il	Corp. Office
N/A		N/A	N/A			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave., Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	27,215,384	270	$ 1,056,638	$ 1,056,638	2,350,918	$ 91,274	1
2	22	Empl Benefits & Taxes		27,215,384		218,957		2,350,918	18,914	2
3	19	Prof Fees & Contracts		27,215,384		3,715,943		2,350,918	320,990	3
4	21	Supplies, Telephone,		27,215,384		535,066		2,350,918	46,220	4
5		Postage, Out. Printing		27,215,384				2,350,918	0	5
6	34	Rental of Space		27,215,384		326,694		2,350,918	28,220	6
7	5	Utilities		27,215,384		31,566		2,350,918	2,727	7
8	6	Bldg Repairs & Maintenance		27,215,384		0		2,350,918	0	8
9	32	Interest		27,215,384		82,750		2,350,918	7,148	9
10	33	Real Estate Taxes		27,215,384		2,822		2,350,918	244	10
11	26	Insurance		27,215,384		151,003		2,350,918	13,044	11
12	27	Advertising & Promotions		27,215,384		49,466		2,350,918	4,273	12
13	25	Transportation		27,215,384		47,462		2,350,918	4,100	13
14	35	Car Rental		27,215,384		5,970		2,350,918	516	14
15	23	Conferences & Conventions		27,215,384		51,384		2,350,918	4,439	15
16	20	Subscriptions, Dues, Awards		27,215,384		64,832		2,350,918	5,600	16
17	21	Furniture & Fixtures		27,215,384		1,593		2,350,918	138	17
18	6	Machinery & Equipment		27,215,384		182		2,350,918	16	18
19	35	Equipment Rental		27,215,384		9,115		2,350,918	787	19
20	6	Equipment Repair & Maint.		27,215,384		67,869		2,350,918	5,863	20
21	20	Employee Recruitment		27,215,384		28,122		2,350,918	2,429	21
22	7	Security & Waste Removal		27,215,384		12,918		2,350,918	1,116	22
23	21	All Other Miscellaneous		27,215,384		4,405		2,350,918	381	23
24	30	Depreciation		27,215,384		337,778		2,350,918	29,178	24
25	TOTALS					$ 6,802,535	$ 1,056,638		$ 587,617	25

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave., Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Salaries & Benefits	44,347,970	270	$ 730,935	$ 730,935	4,132,423	$ 68,110	1
2	22	Empl Benefits & Taxes		44,347,970		96,673		4,132,423	9,008	2
3	19	Prof Fees & Contracts		44,347,970		123,952		4,132,423	11,550	3
4	21	Supplies, Telephone,		44,347,970		44,417		4,132,423	4,139	4
5		Postage, Out. Printing		44,347,970				4,132,423		5
6	34	Rental of Space		44,347,970		7,359		4,132,423	686	6
7	5	Utilities		44,347,970		409		4,132,423	38	7
8	6	Bldg Repairs & Maintenance		44,347,970		577		4,132,423	54	8
9	32	Interest		44,347,970		4,700		4,132,423	438	9
10	33	Real Estate Taxes		44,347,970				4,132,423		10
11	26	Insurance		44,347,970		888		4,132,423	83	11
12	27	Advertising & Promotions		44,347,970				4,132,423		12
13	25	Transportation		44,347,970		22,753		4,132,423	2,120	13
14	35	Car Rental		44,347,970		2,024		4,132,423	189	14
15	23	Conferences & Conventions		44,347,970		8,477		4,132,423	790	15
16	20	Subscriptions, Dues, Awards		44,347,970		208,560		4,132,423	19,434	16
17	21	Furniture & Fixtures		44,347,970		22		4,132,423	2	17
18	6	Machinery & Equipment		44,347,970				4,132,423		18
19	35	Equipment Rental		44,347,970		9,388		4,132,423	875	19
20	6	Equipment Repair & Maint.		44,347,970		2,201		4,132,423	205	20
21	20	Employee Recruitment		44,347,970		18,345		4,132,423	1,709	21
22	7	Security & Waste Removal		44,347,970		81		4,132,423	8	22
23	21	All Other Miscellaneous		44,347,970		4,517		4,132,423	421	23
24	30	Depreciation		44,347,970		18,595		4,132,423	1,733	24
25	TOTALS					$ 1,304,873	$ 730,935		$ 121,592	25

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave., Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	4,165,191	2	$ 97,390	$ 97,390	2,350,918	$ 54,969	1
2	22	Empl Benefits & Taxes		4,165,191		19,879		2,350,918	11,220	2
3	19	Prof Fees & Contracts		4,165,191		1,301		2,350,918	734	3
4	21	Supplies, Telephone,		4,165,191		3,617		2,350,918	2,042	4
5		Postage, Out. Printing		4,165,191				2,350,918		5
6	34	Rental of Space		4,165,191				2,350,918		6
7	5	Utilities		4,165,191				2,350,918		7
8	6	Bldg Repairs & Maintenance		4,165,191				2,350,918		8
9	32	Interest		4,165,191		1,487		2,350,918	839	9
10	33	Real Estate Taxes		4,165,191				2,350,918		10
11	26	Insurance		4,165,191		(1)		2,350,918	(1)	11
12	27	Advertising & Promotions		4,165,191		1,994		2,350,918	1,125	12
13	25	Transportation		4,165,191		5,471		2,350,918	3,088	13
14	35	Car Rental		4,165,191				2,350,918		14
15	23	Conferences & Conventions		4,165,191		3,103		2,350,918	1,751	15
16	20	Subscriptions, Dues, Awards		4,165,191		466		2,350,918	263	16
17	21	Furniture & Fixtures		4,165,191				2,350,918		17
18	6	Machinery & Equipment		4,165,191				2,350,918		18
19	35	Equipment Rental		4,165,191				2,350,918		19
20	6	Equipment Repair & Maint.		4,165,191				2,350,918		20
21	20	Employee Recruitment		4,165,191		35		2,350,918	20	21
22	7	Security & Waste Removal		4,165,191				2,350,918		22
23	21	All Other Miscellaneous		4,165,191		(4,844)		2,350,918	(2,734)	23
24	30	Depreciation		4,165,191		2,045		2,350,918	1,154	24
25	TOTALS					$ 131,943	$ 97,390		$ 74,470	25

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1993 Bond Refinancing		X	Refinance Mortgage	N/A	9/23/93	$ 1,991,385	$ 3,176,050	8/15/01	7.3800	$ 256,039	1
2	1995 Capital Lease		X	Phone System	$1,119.00	11/15/95	56,283		8/16/00	7.1900	52	2
3												3
4												4
5												5
	Working Capital											
6	Mgmt Allocation per Sch VIII	X		Management Allocation	N/A	N/A	N/A	N/A	N/A	N/A	8,425	6
7												7
8												8
9	TOTAL Facility Related				$1,119.00		$ 2,047,668	$ 3,176,050			$ 264,516	9
	B. Non-Facility Related*											
10	Non LTC use of Facility Space			Offset Against Interest Expense	N/A	N/A	N/A	N/A	N/A	N/A	(5,175)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,175)	14
15	TOTALS (line 9+line14)						$ 2,047,668	$ 3,176,050			$ 259,341	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	134,063	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	126,894	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,169)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	129,263	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	122,094	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	100,347	8
	1997	127,393	9
	1998	128,667	10
	1999	127,680	11
	2000	126,110	12

Line 2: Payment of $ 126,894 represents a $ 63,839 for 1999 and $ 63,055 for 2000

Line 4: Accrual of $ 129,263 is based on second half of 2000 of $ 63,839 and estimated first half of 2001 of $65,424

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME P A Peterson Home F/T Aged COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0021238

CONTACT PERSON REGARDING THIS REPORT Dorkas Cruz

TELEPHONE (847) 635-4633 FAX #: (847) 635-6764

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	163B-600 12-19-101-001	3 Stories, Steel Grids, Masonry	$ 126,110.06	$ 124,720.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 126,110.06	$ 124,720.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,000 B. General Construction Type: Exterior Masonry Frame Steel Grids Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	192,020	1985	$ 8,455	1
2					2
3	TOTALS	192,020		$ 8,455	3

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	172		1942	1942	$ 95,858	$	50	$	$	$ 95,858	4
5			1979	1979	5,596,922	139,923	40	139,923		3,078,691	5
6											6
7											7
8											8
	Improvement Type**										
9	1944 Addition			1944	50		50			50	9
10	1948 Addition			1948	157		50			157	10
11	New roof			1969	2,119		25			2,119	11
12	Boiler			1969	5,300		20			5,300	12
13	Ground Improvements			1971	2,400		15			2,400	13
14	New doors			1973	4,326	152	28	152		4,325	14
15	Electric Alarm System			1974	2,056		15			2,056	15
16	1975 Addition			1975	9,226		20			9,226	16
17	Remodeling			1977	10,074		16			10,074	17
18	Addition to Bldg			1980	2,874	74	39	74		1,548	18
19	Grab Bars			1982	6,151		10			6,151	19
20	Automatic Door Controls			1983	10,386		10			10,386	20
21	Remodel Suites to singles			1983	20,550		10			20,550	21
22	Screen patio Cover			1984	1,205		10			1,205	22
23	32 Storm Windows			1984	2,080		10			2,080	23
24	Convert Suites to Rooms			1984	11,900		10			11,900	24
25	Remodel Suites to singles			1986	15,800		10			15,800	25
26	New Drop Ceiling			1991	750	38	10	38		750	26
27	Repair Damaged Roof			1993	4,296	430	10	430		3,224	27
28	Second Floor Redecoration			1994	89,701	8,970	10	8,970		67,140	28
29	Adjustment per IDPA 2nd Flr Decorating			1994	(2,730)		10	(273)	(273)	(2,048)	29
30	Floor Cleaning Equipment			1979	1,360		10			1,360	30
31	Electrical Work			1980	726		10			725	31
32	Painting			1980	3,253		10			3,253	32
33	Carpenting			1980	5,076		10			5,076	33
34	Landscaping			1980	69,073		10			69,073	34
35	Landscaping - Final 1980			1981	7,309		10			7,309	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Nurse call system- Basement	1983	$ 1,700	$	10	$	$	$ 1,700	37
38	Carpeting	1984	1,503		10			1,503	38
39	Nurse Call Control Board	1984	2,900		10			2,900	39
40	Sprinkler System	1984	3,654		10			3,654	40
41	Paving	1985	4,850		10			4,850	41
42	Electrical Wall Fixtures	1985	6,605		10			6,605	42
43	Deluxe Tub with Lift	1986	5,840		10			5,840	43
44	Electrical Wall Fixtures	1986	6,575		10			6,575	44
45	2nd Floor Shower Room	1988	13,898		10			13,898	45
46	Improvements	1988	4,414		10			4,414	46
47	Improvements	1989	15,688		10			15,688	47
48	ADJUSTMENT PER IDPA- 1989 IMPROVEMENTS	1989	20,266		10			20,266	48
49	ADJUSTMENT PER IDPA- 1989 IMPROVEMENTS	1989	35,052		10			35,052	49
50	New Compressor	1989	1,272		7			1,272	50
51	Call Devices	1990	1,400		10			1,400	51
52	New Roof	1990	41,995	1,680	25	1,680		19,320	52
53	Public Address System	1990	4,200		5			4,200	53
54	First Floor Remodeling	1990	62,210	2,488	25	2,488		26,138	54
55	ADJUSTMENT PER IDPA- 1990 1rst Flr Remodeling	1990	(3,590)		25	(144)	(144)	(1,651)	55
56	Parker Bath Tub	1991	9,390		7			9,390	56
57	Cubical Curtains	1991	1,075		7			1,075	57
58	Laundry Room Remodeling	1991	2,082	208	10	208		2,066	58
59	Third Floor Remodeling	1992	99,312	9,931	10	9,931		94,360	59
60	ADJUSTMENT PER IDPA 1992 3rd Flr Remodeling	1992	(78,784)		10	(7,878)	(7,878)	(74,845)	60
61	ADJUSTMENT PER IDPA 1992 3rd Flr Remodeling	1991	54,938		10	2,747	2,747	54,938	61
62	Underground Fual Tank	1993	10,523		5			10,523	62
63	Security Cameras	1993	3,496		5			3,496	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,310,712	$ 163,894		$ 158,346	$ (5,548)	$ 3,710,365	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,310,712	$ 163,894		$ 158,346	$ (5,548)	$ 3,710,365	1
2	Bath Tub	1995	3,766	377	10	377		2,125	2
3	Parking lot	1995	16,425	657	25	657		3,616	3
4	IDPH Remodeling	1995	162,992	16,299	10	16,299		89,713	4
5	New Subacute Unit	1995	677,548	27,102	25	27,102		149,172	5
6	Adjustment per IDPA - 1995 Improv to equip	1995	(63,067)		25	(2,523)	(2,523)	(16,399)	6
7	Adjustment per IDPA - 1995 Improv to CORF	1995	(30,219)		25	(1,208)	(1,208)	(7,855)	7
8	Parking Lot # 94-502	1995	416	42	10	42		229	8
9	Carpet/Vinyl Dining Room	1995	12,220	1,222	10	1,222		6,723	9
10	Glass & Glazing for Door	1997	775	77	10	77		326	10
11	New Doors & Smoke Closet	1997	1,910	191	10	191		764	11
12	Floor Covering in Kitchen	1998	2,047	205	10	205		683	12
13	Repair Roof-P.A.P.	1998	53,433	2,137	25	2,137		6,412	13
14	Zoning Permit Parking Lot	1998	898	90	10	90		262	14
15	Planting & Mulch for P.A.	1998	7,186	719	10	719		2,095	15
16	Parking Lot Expansion	1998	778	78	10	78		227	16
17	North Parking Lot Remodeling	1998	80,391	8,039	10	8,039		23,435	17
18	Consulting N. Parking Lot	1998	806	80	10	80		228	18
19	Repair Conduit Damage	1998	3,982	398	10	398		1,028	19
20	Carpeting for Apartment C	1999	17,200	3,440	5	3,440		6,880	20
21	Corridor Ventilation Upgrade	2000	63,500	2,540	25	2,540		2,742	21
22	Plumbing	2001	2,963	295	10	295		295	22
23	Install Cumberland Print	2001	3,160	126	25	126		126	23
24	Windows	2001	10,000	399	25	399		399	24
25	Porch- Railings-Floors	2001	7,648	305	25	305		305	25
26	Roofing	2001	11,475	1,227	10	1,144	(83)	1,144	26
27	Porch- Railings-Floors	2001	13,612	543	25	543		543	27
28	Fan Coil Unit	2001	5,635	562	10	562		562	28
29	Contract Flooring-Interior	2001	2,920	97	25	97		97	29
30	Wall coverings	2001	2,990	99	25	99		99	30
31	Furniture	2001	36,175	1,280	25	1,197	(83)	1,197	31
32	Carpet-Furnish and instal	2001	1,095	36	25	36		36	32
33	Room Equipment Furniture	2001	4,372	130	25	130		130	33
34	TOTAL (lines 1 thru 33)		$ 7,425,744	$ 232,686		$ 223,241	$ (9,445)	$ 3,987,704	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 7,425,744	$ 232,686		$ 223,241	$ (9,445)	$ 3,987,704	1
2	Room Equipment Furniture	2001	687	20	25	20		20	2
3	Room Equipment Furniture	2001	1,245	37	25	37		37	3
4	Room Equipment Furniture	2001	840	25	25	25		25	4
5	Room Equipment Furniture	2001	1,123	34	25	34		34	5
6	Room Equipment Furniture	2001	5,878	175	25	175		175	6
7	Room Equipment Furniture	2001	550	15	25	15		15	7
8	Room Equipment Furniture	2001	2,534	59	25	59		59	8
9	Carpet Wallpaper	2001	12,410	612	10	612		612	9
10	Furnish and Install Carpet	2001	840	34	10	34		34	10
11	Electric work 3rd Flr Kitchen	2001	3,348	55	25	55		55	11
12	Renovation of Assisted Living	2001	880	3	25	3		3	12
13	Renovation of Assisted Living	2001	4,363	35	10	35		35	13
14									14
15									15
16									16
17	Management Assets- Security System	1999	12,152		10	82	82	N/A	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 7,472,594	$ 233,790		$ 224,427	$ (9,363)	$ 3,988,808	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,049,520	$ 104,390	$ 132,640	$ 28,250	Various	$ 351,816	71
72	Current Year Purchases	328,332	21,934	24,368	2,434	Various	23,446	72
73	Fully Depreciated Assets	455,849				Various	455,849	73
74								74
75	TOTALS	$ 1,833,701	$ 126,324	$ 157,008	$ 30,684		$ 831,111	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Trans.	Handicapped Bus 1991	1991	$ 38,800	$	$	$	7	$ 38,800	76
77										77
78										78
79										79
80	TOTALS			$ 38,800	$	$	$		$ 38,800	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,353,550	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 360,114	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 381,435	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 21,321	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,858,719	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	95 Improvement -CORF 1995	$ 30,219	$ 1,208	$ 7,855	86
87	96 Dodge Van 1997	17,032	1,634	10,602	87
88					88
89	Management Autos	10,701	1,280	N/A	89
90					90
91	TOTALS	$ 57,952	$ 4,122	$ 18,457	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 33,605 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Nurses are trained prior to being hired

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	N/A			
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts		N/A					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number P A Peterson Home F/T Aged **#** 0021238 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	N/A		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$	48

***(See instructions.)**

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ N/A	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	24 *

Note: Lutheran Social Services of Illinois is unable to provide meaninful comparative balance sheets or statements of changes in equity for individual programs due to the commingling of cash, other asset and most liabilities in a complex, multi-functional service agency.

Any Balance Sheet prepared with only those Assets with specific programs would not balance or present a meaningful picture of that program's Financial Status.

*** This must agree with page 17, line 47.**

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,014,529	1
2	Discounts and Allowances for all Levels	(150,280)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,864,249	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,701	13
14	Non-Patient Meals	8,090	14
15	Telephone, Television and Radio	25,163	15
16	Rental of Facility Space	1,910	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	166	20
21	Other Medical Services		21
22	Laundry	23,055	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 61,085	23
	D. Non-Operating Revenue		
24	Contributions	111,365	24
25	Interest and Other Investment Income***	62	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 111,427	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Machine Income	2,061	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,061	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,038,822	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,307,775	31
32	Health Care	3,826,847	32
33	General Administration	1,814,118	33
	B. Capital Expense		
34	Ownership	764,528	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	66,327	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,779,595	40
41	**Income before Income Taxes (line 30 minus line 40)****	259,227	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 259,227	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,627	1,880	$ 51,833	$ 27.57	1
2	Assistant Director of Nursing	12,142	13,527	172,563	12.76	2
3	Registered Nurses	33,661	37,234	724,555	19.46	3
4	Licensed Practical Nurses	29,243	32,411	484,080	14.94	4
5	Nurse Aides & Orderlies	82,184	88,591	1,021,336	11.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	362	398	3,874	9.73	8
9	Activity Director	4,650	5,554	98,869	17.80	9
10	Activity Assistants					10
11	Social Service Workers	2,740	3,208	47,588	14.83	11
12	Dietician					12
13	Food Service Supervisor	3,007	3,900	54,229	13.90	13
14	Head Cook	6,342	6,857	61,851	9.02	14
15	Cook Helpers/Assistants	22,150	24,119	172,411	7.15	15
16	Dishwashers					16
17	Maintenance Workers	6,987	7,910	111,217	14.06	17
18	Housekeepers	14,694	16,285	117,012	7.19	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	1,721	1,940	67,108	34.59	21
22	Other Administrative	2,660	3,066	52,725	17.20	22
23	Office Manager					23
24	Clerical	9,791	10,680	96,523	9.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	9,454	10,502	104,782	9.98	31
32	Other Health Care(specify)					32
33	Other(specify)	1,041	1,104	24,257	21.97	33
34	TOTAL (lines 1 - 33)	244,456	269,166	$ 3,466,813 *	$ 12.88	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 34,263	1,3	35
36	Medical Director	As Needed	18,707	9,3	36
37	Medical Records Consultant	As Needed	665	10,3	37
38	Nurse Consultant	As Needed	52	10,3	38
39	Pharmacist Consultant	As Needed	1,700	10,3	39
40	Physical Therapy Consultant	As Needed	506,224	10a,3	40
41	Occupational Therapy Consultant	As Needed	125,044	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	67,716	10a,3	43
44	Activity Consultant	As Needed	617	19,3	44
45	Social Service Consultant				45
46	Other(specify) (see Attached)	As Needed	97,314	Various	46
47	Legal & Audit/Accounting	As Needed	60,203	19,3	47
48					48
49	TOTAL (lines 35 - 48)		$ 912,505		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	As Needed	2,135		52
53	TOTAL (lines 50 - 52)		$ 2,135		53

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peggy J. Holt	Administrator	0	$ 67,108
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 67,108

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Duane Morris & Heckscher	Legal Fees	$ 21,373
Frost Ruttenberg and Roth	Medicare Consultant	6,605
Il Dep Public Health	Legal Fees	500
John Satter	Legal Fees	1,052
Littler Menderson	Legal Fees	270
Transworld	Collection Services	506
LSSI	Management Services	717,478
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 747,784

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 110,113
Unemployment Compensation Insurance	32,698
FICA Taxes	254,381
Employee Health Insurance	336,084
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	(67,666)
Management Allocation	39,142
TOTAL (agree to Schedule V, line 22, col.8)	$ 704,752

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,262
Health Care Worker Background Check (Indicate # of checks performed)	
Licenses & Fees	
Advertising & Promotion, Awards, Grants	15,916
Subscriptions and Books	2,241
Membership Dues	12,260
Management Allocation	29,455
Less: Public Relations Expense	( )
Non-allowable advertising	(15,916)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,218

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Vehicle Operating Cost	892
Employee Mileage Pyments	5,305
Meals, Lodging	674
Seminar Expense	4,600
Conference & Covention	1,665
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,136

**See instructions.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6	N/A												
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number P A Peterson Home F/T Aged **#** 0021238 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $ 4,240.15**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,021** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,327**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8,090**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Clifton Gunderson** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **In Progress, will send as soon as availa**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.